

PGY-2 – INFECTIOUS DISEASES PHARMACY RESIDENCY APPLICATION

Please PRINT clearly

Name: _____ Social Security#: _____

(Last, First, Middle Initial)

Current Address: _____

City

State

Zip Code

Telephone: _____

Date effective to: _____

Email: _____

Permanent Address: _____

City

State

Zip Code

Telephone: _____

E-mail: _____

APPLICATION CHECKLIST

All applications have to include the following, and are due January 9, 2009.

- Application form
- Letter of intent
- Curriculum vitae
- College transcript
- Letters of recommendation (3)

Will you be able to start the program on July 1, 2009? Yes No

If "no", please explain:

I certify that all information in the application materials is complete and accurate to the best of my knowledge.

Signature _____ Date _____

Please send all completed applications to:

Christine Kubin, PharmD, BCPS
Program Director
Pharmacy Specialty Residency Program
Pharmacy Department
NewYork-Presbyterian Hospital
630 West 168th Street
PH 8 West – 876
New York, NY 10032

Phone: (212) 305-0610
Fax: (212) 342-2957
Email: chk9005@nyp.org